Public Laws; 101st Congress / 1st Session / House Hearings / 1989

101ST CONGRESS
1ST SESSION

H. R. 1845

To amend the Public Health Service Act, the Fair Labor Standards Act of 1938, and title XIX of the Social Security Act, to provide basic health benefits for all Americans.

IN THE HOUSE OF REPRESENTATIVES

APRIL 12, 1989

Mr. WAXMAN (for himself, Mr. CLAY, Mr. HAWKINS, Mr. LELAND, and Mr. MURPHY) introduced the following bill; which was referred jointly to the Committees on Education and Labor and Energy and Commerce

---

A BILL

To amend the Public Health Service Act, the Fair Labor Standards Act of 1938, and title XIX of the Social Security Act, to provide basic health benefits for all Americans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Basic Health Benefits for All Americans Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 101. BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) REQUIREMENT.—The Public Health Service Act is amended—

(1) by redesignating title XXVI (42 U.S.C. 300cc et seq.) as title XXVII; and

(2) by inserting after title XXV (42 U.S.C. 300bb–1 et seq.) the following new title:

"TITLE XXVI—BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"SEC. 2601. HEALTH BENEFITS.

"(a) IN GENERAL.—Each employer shall, in accordance with title III of the Basic Health Benefits for All Americans Act, enroll each of its employees and their families in a health benefit plan.

"(b) ENFORCEMENT.—

"(1) INELIGIBILITY FOR ASSISTANCE.—An employer that is a State or political subdivision of a State or an agency or instrumentality of a State or political subdivision and that does not comply with subsection (a) shall not be eligible to receive a grant, contract, loan, or loan guarantee under this Act.

"(2) GENERAL ENFORCEMENT PROVISIONS.—Any employer that does not comply with subsection (a) shall be subject to section 332 of the Basic Health Benefits for All Americans Act.

"(c) DEFINITIONS.—The terms used in this section have the meanings prescribed for the terms by section 303 of such Act.".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2601 through 2616 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2701 through 2716, respectively.

(2)(A) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are each amended by striking out "2601" and inserting "2701".

(B) Section 305(i) of such Act (42 U.S.C. 242c(i)) is amended by striking out "2611" each place it appears and inserting "2711".

TITLE II—AMENDMENTS TO FAIR LABOR STANDARDS ACT OF 1938 AND EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 201. BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) HEALTH BENEFITS.—The Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.) is amended by adding at the end thereof the following new title:

"TITLE II—BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"SEC. 201. HEALTH BENEFITS.

"(a) IN GENERAL.—Each employer shall, in accordance with title III of the Basic Health Benefits for All Americans Act, enroll each of its employees and their families in a health benefit plan.

"(b) ENFORCEMENT.—Any employer that does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall be subject to section 332 of the Basic Health Benefits for All Americans Act.

"(c) DEFINITIONS.—The terms used in this section have the meanings prescribed for the terms by section 303 of such Act.".

(b) CONFORMING AMENDMENTS.—

(1) The Fair Labor Standards Act of 1938 is amended by striking the first section and inserting the following:

"SECTION 1. SHORT TITLE.

"This Act may be cited as the 'Fair Labor Standards Act of 1938'.

"TITLE I—WAGES AND HOURS".

(2) The Fair Labor Standards Act of 1938 is amended by striking "this Act" each place it occurs and inserting "this title".

SEC. 202. PREEMPTION UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(2)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraph:

"(C) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any provision of the law of any State to the extent that such provision regulates, or otherwise provides any requirement relating to, contracts or policies of insurance issued to or under a health benefit plan under title III of the Basic Health Benefits for All Americans Act.

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 3 of such Act (29 U.S.C. 1002(1)) is amended by adding at the end the following new sentence: "Such terms include a health benefit plan established in accordance with title III of the Basic Health Benefits for All Americans Act.".

TITLE III—REQUIREMENTS FOR HEALTH BENEFIT PLANS FOR EMPLOYEES AND THEIR FAMILIES

Subtitle A—Requirement and Definitions

SEC. 301. EMPLOYER REQUIREMENT TO ENROLL EMPLOYEES AND FAMILIES IN HEALTH BENEFIT PLANS.

(a) IN GENERAL.—This title shall apply to employers required to enroll employees and their families in health benefit plans under section 2601(a) of the Public Health Service Act or under section 201(a) of the Fair Labor Standards Act of 1938.

(b) TYPES OF PLANS PERMITTED.—

(1) IN GENERAL.—Except as required under paragraph (2), an employer may meet the requirements of this title by means of enrollment in any health benefit plan.

(2) PROVISION OF HEALTH BENEFIT PLANS THROUGH REGIONAL INSURERS.—

(A) EMPLOYERS REQUIRED TO USE REGIONAL INSURERS.—

(i) EMPLOYERS WITHOUT A HEALTH BENEFIT PLAN.—Except as permitted under subparagraph (B)(ii) and subparagraph (C), each employer, that does not have its employees enrolled in a health benefit plan on the day before the effective date of this Act, shall meet the requirements of this title by means of enrollment in any health benefit plan of a regional insurer (as defined in section 303(12)).

(ii) SMALL EMPLOYERS CHANGING INSURERS.—Each small employer that—

(I) has its employees enrolled in a health benefit plan on or before the day before the effective date of this title, but

(II) subsequently, on or after the effective date of this title, changes the insurer offering the plan under which those employees are (or may be) enrolled or changes the plan from a self-insured plan to a plan of an insurer,

shall, except as provided in subparagraph (C), then meet the requirements of this title by means of enrollment of those employees in any health benefit plan of a regional insurer.

(B) CONTINUED USE OF REGIONAL INSURERS REQUIRED.—

(i) IN GENERAL.—If an employer meets the requirements of this title by means of enrollment of employees and families in any health benefit plan of a regional insurer, except as permitted under subparagraph (ii) and under subparagraph (C), the employer shall continue to meet such requirements by means of enrollment of such employees and families in such a plan.

(ii) EXCEPTION FOR CERTAIN LARGE EMPLOYERS.—A large employer (other than an employer that was a large employer on

the day before the effective date of this title) that meets the requirements of this title by means of enrollment of employees in any health benefit plan of a regional insurer may elect to meet the requirements of this title with respect to such employees other than by means of enrollment in a health benefit plan of a regional insurer. If such an election is made and so long as the employer remains a large employer, the regional insurer may not make any health benefit plan of that insurer under section 323 available for enrollment of employees and families of that employer.

(C) CERTAIN PLANS.—Subparagraphs (A) and (B) shall not apply to an employer which maintains or contributes to a plan described in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(37)).

SEC. 302. COVERAGE OF EMPLOYEES AND FAMILY MEMBERS.

(a) REQUIREMENT.—Except as permitted under subsections (b) and (d) and section 313(c)—

(1) enrollment of an employee in a health benefit plan under this title includes enrollment of the employee's family in the plan; and

(2) enrollment of the employee or the employee's family in a health benefit plan may not be waived by the employee.

(b) EXCEPTIONS TO AVOID DUPLICATE FAMILY COVERAGE.—

(1) SPOUSE OR PARENT EMPLOYED.—An employee, at the employee's option, may waive enrollment in a health benefit plan under this title for the spouse or a child of the employee but only for such period as the employee demonstrates that such spouse or child, respectively, is actually covered under a health benefit plan.

(2) CHILD EMPLOYED.—A child who is employed (or a parent on the child's behalf) may waive enrollment in a health benefit plan provided by the child's employer during any period in which the child otherwise is covered under a health benefit plan.

(c) NONDISCRIMINATION BASED ON FAMILY STATUS.—An employer may not fail or refuse to hire, and may not discharge or otherwise discriminate against, any individual because the individual has a spouse or child and such employer is required under this title to enroll the spouse or child in a health benefit plan.

(d) WAIVER IN CASE OF MULTIPLE EMPLOYERS.—In the case of an individual who is an employee (other than a

less-than-full-time employee) with respect to more than one employer, the employee may waive enrollment in the health benefit plan of any such employer, but only if the employee is, and certifies to the employer that the employee is, enrolled in the health benefit plan of one employer.

SEC. 303. DEFINITIONS.

In this title:

(1) CHILD.—The term "child" means, with respect to an employee, an individual—

(A) who (i) is under 18 years of age, (ii) is under 23 years of age and a full-time student, or (iii) is an unmarried, dependent child, regardless of age, who is incapable of self-support because of mental or physical disability which existed before age 22; and

(B)(i) who is the biological, adopted, or foster child of the employee or the employee's spouse,

(ii) who is the legal ward of the employee or the employee's spouse, or

(iii) with respect to whom the employee or employee's spouse, stands in loco parentis during the course of an adoption application.

(2) EFFECTIVE DATE OF THIS TITLE.—The term "effective date of this title" means January 1 of the

second year that begins after the date of the enactment of this Act.

(3) EMPLOYEE.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term "employee" means, with respect to an employer, an individual who normally performs on a monthly basis 17½ hours of service per week for that employer.

(B) HANDICAPPED WORKERS.—The term "employee" does not include an individual described in section 14(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 214(c)).

(C) CERTAIN EMPLOYERS.—The term "employee" means, with respect to an employer described in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(37)), an individual who performs—

(i) 17½ hours of service per week for the employer; or

(ii) an equivalent amount of service during a 1-, 3-, or 6-month period for the employer, as determined under regulations issued by the Secretary.

(D) LESS-THAN-FULL-TIME EMPLOYEE DEFINED.—The term "less-than-full-time employee"

means, with respect to an employer, an employee who normally performs on a monthly basis less than 25 hours of service per week for that employer.

(E) CONSULTANTS AND CONTRACTORS.—The term "employee" shall include an individual who is a consultant or contractor of an employer if the Secretary determines that the consulting arrangement or contract was entered into to avoid the requirements of this title.

(4) EMPLOYER.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term "employer" means—

(i) an employer that is required to pay the individuals it employs the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206) (or would be required to pay such wage but for the dollar volume standards prescribed in section 3(s) of such Act (29 U.S.C. 203(s)) or the exemptions prescribed in section 13(a) of such Act (29 U.S.C. 213(a))); and

(ii) any State or political subdivision thereof, or any agency or instrumentality thereof.

(B) DOMESTIC SERVICE EMPLOYERS.—The term "employer" shall not include an employer that is required to pay the individuals it employs the minimum wage prescribed by section 6(f) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(f)) (or would be required to pay the minimum wage prescribed by section 6 of such Act but for section 13(a)(15) of such Act (29 U.S.C. 213(a)(15)).

(C) OWNER-OPERATORS.—An owner-operator of a business shall be considered to be both an employer and employee with respect to himself or herself if the owner-operator has one or more employees who are required to be enrolled under a health benefit plan of the owner-operator.

(D) SMALL AND LARGE EMPLOYER.—The term "small employer" means, with respect to a calendar year, an employer that normally employs fewer than 26 employees on a typical business day during the calendar year, and the term "large employer" means an employer that is not a small employer.

(E) APPLICATION OF CONTROLLED GROUP RULES.—Section 607(4) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(4)) shall apply in the determination under this title of whether an employer is a large or small employer and the number of employees an employer normally employs.

(5) FAMILY AND FAMILY MEMBER.—The terms "family" and "family member" mean, with respect to an employee, the employee's spouse and children.

(6) HEALTH BENEFIT PLAN.—The term "health benefit plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) that—

(A) provides medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise; and

(B) meets the requirements of section 311.

(7) HEALTH INSURANCE REGION.—The term "health insurance region" means such a region designated under section 321.

(8) INSURER.—The term "insurer" means an entity qualified under the law of a State to offer insurance or provide health benefits in that State.

(9) MENTAL DISORDER.—The term "mental disorder" has the same meaning given such term in the International Classification of Diseases, 9th Revision, Clinical Modification.

(10) NONGOVERNMENTAL EMPLOYER.—The term "nongovernmental employer" means an employer not described in paragraph (4)(A)(ii).

(11) PHYSICIAN SERVICES.—The term "physician services" means professional medical services lawfully provided by a physician under State medical practice acts, and includes professional services provided by a dentist or a licensed advanced-practice nurse acting within the scope of their practices (as determined under State law) if such services would be treated as physician services if furnished by a physician.

(12) REGIONAL INSURER.—The term "regional insurer" means an insurer or group of insurers certified as a regional insurer under section 322.

(13) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(14) STATE.—The term "State" includes the District of Columbia and, except for purposes of paragraph (8), also includes Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, and American Samoa.

(15) TAILORED HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term "tailored health benefit plan" means a plan that—

(i) but for subparagraph (B), would be health benefit plan, and

(ii) has an actuarial value of benefits (as defined in section 311(b)(8)) at least equivalent to ½ of the actuarial value of benefits otherwise required of a health benefit plan.

(B) LIMITATION ON SERVICES.—A tailored health benefit plan may, in accordance with regulations of the Secretary, limit the scope and duration of services but only in a manner that emphasizes coverage of ambulatory services.

Subtitle B—Requirements for Health Benefit Plans

SEC. 311. GENERAL REQUIREMENTS; PERMITTING ACTUARIALLY EQUIVALENT PLANS.

(a) GENERAL REQUIREMENTS.—Subject to subsections (b) and (c), in order for a health benefit plan to meet the requirements of this section, the plan shall—

(1) provide benefits for items and services in accordance with section 312;

(2) provide coverage of employees and family enrolled in the plan in accordance with section 313; and

(3) provide for premiums, deductibles, copayments, and coinsurance in accordance with section 314.

(b) ACTUARIALLY EQUIVALENT PLANS PERMITTED.—

(1) VARIATIONS IN PREMIUMS, DEDUCTIBLES, AND COST-SHARING.—A health benefit plan also meets the requirements of this section notwithstanding that it does not meet one or more requirements of section 314 (relating to premiums, deductibles, copayments, coinsurance, and limit on out-of-pocket expenses), other than the requirement of section 314(b)(2)(A), if the actuarial value of benefits under the plan (as defined in paragraph (8)) is not less than the equivalent of the actuarial value of benefits under the plan that would have applied if the plan met the requirements described in subsection (a).

(2) MINIMUM REQUIREMENTS.—Nothing in this subsection shall be construed as not requiring each plan—

(A) to meet the requirements of sections 312(a)(4) and 313; or

(B) to establish a limit on out-of-pocket expenses under section 314(d), except that this subparagraph shall not be construed to require the

establishment of the out-of-pocket limit described in section 314(d)(5)(B).

(3) MENTAL HEALTH BENEFITS.—Notwithstanding any other provision of law, a health benefit plan may meet the requirements of section 312(a)(5) by including payment for any combination of benefits specified in subparagraphs (A) and (B) of such section if the plan includes payment for—

(A) benefits the value of which is at least actuarially equivalent to the value of the benefits for which payment is otherwise required under such subparagraphs; and

(B) both types of benefits described in each of such subparagraphs.

(4) ADVISORY BOARD.—

(A) ESTABLISHMENT.—The Secretary shall establish an Advisory Board to advise the Secretary on the development of actuarial equivalency standards and such other matters relating to the administration of this title as the Secretary or the Board considers appropriate.

(B) MEMBERSHIP.—The Advisory Board shall consist of 13 members appointed by the Secretary, of whom—

(i) four members shall be representatives of employers, who shall be experienced in the administration of and knowledgeable about health insurance and actively engaged in the management or design of health insurance programs, of which—

(I) two members shall be representatives of large businesses; and

(II) two members shall be representatives of small businesses;

(ii) two members shall be representatives of labor organizations, who shall possess the qualifications described in clause (i);

(iii) two members shall be representatives of the insurance industry, at least one of whom shall be knowledgeable about small group policies;

(iv) two members shall be actuaries, who shall be experienced in the administration of and knowledgeable about health insurance programs; and

(v) three members shall be representatives of the general public not described in clauses (i) through (iv).

(C) TERMS.—Each member of the Advisory Board shall serve for a term of 4 years, except that members first appointed shall serve for staggered terms, as designated by the Secretary. A member may serve on the Board after the expiration of the term of the member until a successor has taken office as a member of the Board.

(D) COMPENSATION.—The members of the Advisory Board may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, while away from their homes or regular places of business, for each day (including travel time) during which they are attending meetings or conferences of the Advisory Board or otherwise engaged in the business of the Board.

(E) DEVELOPMENT OF ACTUARIAL EQUIVALENCY VARIATIONS.—Not later than 6 months before the effective date of this title, the Advisory Board shall develop and transmit to the Secretary—

(i) at least three model health plans each with an actuarial value of benefits that is equivalent to the actuarial value of bene-

fits of a minimum plan (as defined in paragraph (9));

(ii) a table of actuarial equivalency describing permitted expansions in covered services and variations in copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under a health plan, as a percentage increase or decrease in the actuarial value of the minimum plan, with the table describing as many expansions and variations as practicable in order to facilitate compliance with this section; and

(iii) recommendations for procedures to facilitate the process by which an employer may certify actuarial equivalency for plan variations not provided in the model health plans or the table of actuarial equivalency and for the certification of multiple plans offered by the same employer.

(F) REVIEW OF CHANGES.—The Advisory Board shall review proposed changes to the minimum benefit package required of health benefit plans and transmit a cost benefit analysis of such

changes, along with recommendations, to Congress and the Secretary.

(5) TABLE OF ACTUARIAL EQUIVALENCY.—The Secretary shall publish, at least 3 months prior to the effective date of this title, a table that specifies the percentage increase or decrease in the actuarial value of benefits under a health benefit plan providing only the required benefits resulting from variations in covered services, copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under a health benefit plan. The table shall describe as many variations as feasible. In developing the table, the Secretary shall consider the recommendations of the Advisory Board established in paragraph (4).

(6) COMPLIANCE WITH FIDUCIARY DUTIES.—In the case of health benefit plan variations for which relative actuarial values are not expressly provided for in the table published under paragraph (5) or in the case of variations in which one or more elements of covered services, copayments, deductibles, and limits on out-of-pocket expenses are given a relative actuarial value by the plan administrator that is different from that provided by such table, the plan shall not be considered out of compliance with this section—

(A) if, under a process consistent with the duties of a fiduciary under part 4 of title I of the Employee Retirement Income Security Act of 1974, it is established that, and an actuary meeting credentials established by the American Academy of Actuaries or by the Secretary has certified that, the actuarial value of the benefits of the plan is at least equivalent to the actuarial value of the benefits of a minimum plan; and

(B) until and unless the Secretary has determined that such variations are not in compliance with the requirements of this section.

(7) MULTIPLE PLANS.—In the case of an employer that has a health benefit plan that meets the requirements of paragraph (6)(A) or is otherwise determined to have an actuarial value of benefits that is at least equivalent to the actuarial value of a minimum plan, the Secretary shall establish by regulation streamlined procedures for the approval of additional health benefit plans the actuarial value of the benefits of which is at least equivalent to the actuarial value of the benefits of the approved health benefit plan.

(8) ACTUARIAL VALUE OF BENEFITS DEFINED.—For purposes of this subsection, a plan's ''actuarial value of benefits'' is the amount by which the total of

the amounts payable as benefits under the plan exceeds the amount of the premiums, deductibles, copayments, and coinsurance payable by the employee under the plan, as determined on an actuarial basis per enrollee for a plan year.

(9) MINIMUM PLAN DEFINED.—For purposes of this subsection, the term "minimum plan" means a health benefit plan that only provides the minimum benefits required under this title.

(c) NEW SMALL BUSINESSES.—In the case of a small employer that normally employs 10 or fewer employees on a typical business day during a year and that has been an employer for 2 or fewer years, the employer may meet the requirements of this section by means of enrollment in a tailored health benefit plan (as defined in section 303(15)), rather than a health benefit plan.

SEC. 312. REQUIREMENTS RELATING TO COVERED ITEMS AND SERVICES.

(a) IN GENERAL.—Except as otherwise provided in this section, a health benefit plan shall include payment for—

(1) inpatient and outpatient hospital care, except that treatment for a mental disorder is subject to the special limitations described in paragraph (5)(A);

(2) inpatient and outpatient physician services, except that psychotherapy or counseling for a mental

disorder is subject to the special limitations described in paragraph (5)(B);

(3) diagnostic and screening tests;

(4) prenatal care and well-baby care provided to children who are 1 year of age or younger; and

(5)(A) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of inpatient care may be substituted for days of partial hospitalization according to a ratio established by the Secretary; and

(B) outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a provider who is acting within the scope of State law and who—

(i) is a physician; or

(ii) meets the standards of subsection (g)(2)(B) and is a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, or a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services.

(b) EXCEPTIONS.—Subsection (a) shall not be construed as requiring a plan to include payment for—

(1) items and services that are not medically necessary;

(2) routine physical examinations or preventive care (other than prenatal care and well-baby care covered under subsection (a)(4)); or

(3) experimental services and procedures.

(c) AMOUNT, SCOPE, AND DURATION OF CERTAIN BENEFITS.—Except as provided in subsection (b), a health benefit plan shall place no limits on the amount, scope, or duration of benefits described in paragraphs (1) through (3) of subsection (a).

(d) AMOUNT, SCOPE, AND DURATION OF PRENATAL CARE AND WELL-BABY CARE.—A health benefit plan may limit the amount, scope, and duration of prenatal care and well-baby care described in subsection (a)(4) pursuant to regulations of the Secretary specifying the amount, scope, and duration of such care. The Secretary shall develop such regulations after consultation with appropriate medical experts.

(e) LIMITATIONS.—

(1) PANELS AND MANAGED CARE SYSTEMS.—Nothing in this Act shall prohibit a health benefit plan from providing benefits for the items and services described in this section through a panel or other form of managed care system, and from selecting particular health care providers or types, classes, or categories of

health care providers to participate in such panel or managed care system. Such panel or managed care system shall provide, in accordance with regulations issued by the Secretary, reasonable access to care by plan enrollees.

(2) DIFFERENT LEVELS OF PAYMENTS.—Nothing in this Act shall prohibit a health benefit plan from establishing a different level of payments for reimbursement for different health care providers furnishing the benefits for the items and services described in this section.

(3) HEALTH CARE PROVIDERS.—Nothing in this Act shall be construed to require a health benefit plan to utilize any health care provider (or type, class, or category of health care provider) to provide benefits for the items and services described in this section that were provided by the plan before the effective date of this title, other than the health care providers being utilized by the health benefit plan on such effective date, except that this paragraph shall not apply to duly licensed or certified clinical psychologists (acting within the scope of State law) after the end of the 5-year period beginning on the effective date of this title. The previous sentence shall not apply to health benefit plans offered by regional insurers under subtitle C.

(4) DENIAL OF PAYMENT TO EXCLUDED PROVIDERS.—Nothing in this Act shall require a health benefit plan to make payment to any health care provider that is excluded from participation in any Federal health care program.

(f) BASIS OF PAYMENT MAY DIFFER FROM ACTUAL CHARGES.—The requirement of payment for services described in subsection (a) shall not prevent an insurer from establishing a fee schedule or other basis of payment that is different from actual charges, but only if such fee schedule or other basis provides, pursuant to regulations of the Secretary, for payment at a level sufficient to achieve adequate access to services covered by the plan without additional out-of-pocket expenses for the covered service (but for copayments and deductibles permitted under section 314).

(g) MENTAL HEALTH CARE.—

(1) INPATIENT CARE.—With respect to inpatient hospital care described in subsection (a)(5)(A), subject to the provisions of subsection (e), such care shall include reimbursement for professional care, provided to the individual while receiving such inpatient care, provided by a physician or duly licensed or certified clinical psychologist operating within the scope of practice of the physician or psychologist, as determined under State law. Nothing in this subsection shall be con-

strued to modify hospital practices with regard to scope of practice, admitting privileges, or billing arrangements.

(2) OUTPATIENT CARE.—

(A) USE OF PROVIDERS.—With respect to outpatient psychotherapy described in subsection (a)(5)(B) and subject to the provisions of subsection (e), a health benefit plan which provided benefits with respect to outpatient psychotherapy before January 1, 1989, is not required under subsection (a)(5)(B) to provide benefits for outpatient psychotherapy provided by any health care provider (or type, class, or category of health care provider described in subsection (a)(5)(B)(ii), other than physicians or duly licensed or certified clinical psychologists), other than health care providers being utilized by the plan on January 1, 1989.

(B) STANDARDS FOR CERTAIN PROVIDERS.—The Secretary shall establish standards that providers referred to in subsection (a)(5)(B)(ii) must meet to be eligible for payment under a health benefit plan.

SEC. 313. REQUIREMENTS RELATING TO TIMING OF COVERAGE AND PROHIBITION OF PREEXISTING CONDITION LIMITATIONS.

(a) DATE OF INITIAL COVERAGE.—In the case of an employee (and family members) enrolled under a health benefit plan provided by an employer, the coverage under the plan must begin not later than the latest of the following:

(1) 30 days after the day on which the employee first performs an hour of service as an employee of that employer.

(2) The first day on which the employer is required to meet the requirements of this title.

(3) In the case of an employer which maintains or contributes to a plan referred to in section 301(b)(2)(C)—

(A) 90 days after the date on which the employee first performs an hour of plan-covered service as an employee of the employer, except that if the initial waiting period is longer than 30 days, coverage under the plan shall continue for an equivalent period after the last day on which the employee performs an hour of plan-covered service as an employee of the employer; or

(B) 180 days after the day on which the employee first performs an hour of plan-covered service, except that if the initial waiting period is

longer than 30 days, coverage under the plan shall continue for an equivalent period after the last day on which the employee performs an hour of plan-covered service.

(4) In the case of a child, coverage applies for any period during which the employee who is the child's parent is covered (subject to section 302(b)).

(b) PROHIBITION OF PRE-EXISTING CONDITION PROVISIONS.—A health benefit plan may not exclude or otherwise limit any individual from coverage under the plan on the basis that the individual has (or at any time has had) any disease, disorder, or condition.

(c) RIGHT TO WAIVE ENROLLMENT.—

(1) LESS-THAN-FULL-TIME EMPLOYEES WITH INCREASED PREMIUMS.—In the case of a less-than-full-time employee who is subject to, and is charged, an increased premium under section 314(b)(5), the employee may, notwithstanding any other provision of this title, waive enrollment under this title. Such waiver shall be exercised in such form and manner as the Secretary shall specify and shall terminate upon the employee no longer being subject to, and charged, such an increased premium.

(2) EMPLOYER CONTRIBUTION TO PUBLIC PLAN.—In the case of a less-than-full-time employee

who waives enrollment under paragraph (1), the employer is required, in a manner specified by the Secretary, to make a payment to the State or other entity providing health benefits under the program established by the amendments made by title IV of this Act equal to the minimum amount the employer would have made towards the health care costs of the employee if the employee had not waived such enrollment. Such payments shall be credited towards Federal expenditures required to carry out such program.

SEC. 314. REQUIREMENTS RELATING TO PREMIUMS, DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND LIMIT ON OUT-OF-POCKET EXPENSES.

(a) ENROLLEE COST-SHARING PERMITTED.—A health benefit plan may require an enrollee to pay for premiums, deductibles, copayments, and coinsurance amounts for coverage under the plan, but only if the premiums, deductibles, copayments, and coinsurance do not exceed the limitations imposed under this section.

(b) LIMITATION ON PREMIUMS.—

(1) MONTHLY PREMIUM LIMITED TO 20 PERCENT OF ACTUARIAL RATE.—

(A) IN GENERAL.—Subject to paragraph (5), a health benefit plan may not require an employee to pay a premium—

(i) for coverage for a period of longer than one month; or

(ii) the amount of which on a monthly basis exceeds 20 percent of the monthly actuarial rate defined under subparagraph (B).

(B) MONTHLY ACTUARIAL RATE DEFINED.—For purposes of this subsection, the term "monthly actuarial rate" means, with respect to a health benefit plan in a plan year, the average monthly per enrollee amount that the employer providing the plan estimates, for enrollees under the plan during the year, would be necessary to pay for the total benefits required under the plan (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year.

(C) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of this paragraph, a health benefits plan may provide for the premium to be applied, and the monthly actuarial rate to be computed—

(i) separately for employees who have family members covered under the plan and for employees who do not have family members covered under the plan, and

(ii) with respect to employees with such covered family members, separately (I) for employees who have a covered spouse and one or more covered children, (II) for employees who have a covered spouse but no covered children, and (III) for employees who do not have a covered spouse but have one or more covered children.

(D) ADJUSTMENT FOR COVERED SPOUSE WITH OTHER COVERAGE.—For purposes of this paragraph, if a health benefit plan charges an employee for a share of the premium, the plan shall establish a separate premium category (or categories) for family coverage in the case of a covered spouse who is receiving primary health insurance coverage from another health benefit plan. The premium for such categories shall be established based on actual or projected plan experience or according to a formula established by the Secretary.

(E) ADJUSTMENT OF PREMIUMS FOR EMPLOYED RETIREES UNDER HEALTH BENEFIT PLANS.—If an employer provides a health benefit plan with respect to retirees and the plan charges a retiree for a share of the premium of the plan,

in the case of such a retiree who is enrolled as an employee (or dependent) under a health benefit plan under this title, the health benefit plan with respect to the retiree must provide for an adjustment of the amount of the retiree's premium in order to take into account the reduction in health insurance costs resulting from such coverage.

(2) NO PREMIUM FOR LOW INCOME EMPLOYEES FOR AT LEAST 1 HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—Each employer with an employee whose hourly wage rate is less than the hourly wage rate specified in subparagraph (B) shall offer each such employee at least one health benefit plan that does not require a premium for such employee.

(B) HOURLY RATE.—The hourly wage rate specified in this subparagraph for premiums paid in a plan year beginning in a calendar year is 125 percent of the minimum wage rate prescribed by section 6 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206) for that year. If the rate computed under the previous sentence is not a multiple of 1 cent it shall be rounded to the next highest multiple of 1 cent.

(3) PAYMENT OF PREMIUMS.—An employee enrolled under a health benefit plan is liable for payment of premiums required under that plan in accordance with this subsection.

(4) WITHHOLDING PERMITTED.—No provision of State law shall prevent an employer of an employee enrolled under a health benefit plan established under this title from withholding the amount of any premium due by the employee from the payroll of the employee.

(5) SPECIAL RULE FOR LESS-THAN-FULL-TIME EMPLOYEES.—In the case of a less-than-full-time employee (as defined in section 303(2)(D)) who is not described in paragraph (2)(A), a health benefit plan may require the employee to pay a premium the amount of which (on a monthly basis) does not exceed—

(A) 100 percent, minus

(B) 80 percent, multiplied by the ratio of (i) the average number of hours per week the employee is normally employed by the employer in the calendar quarter to (ii) 25,

of the monthly actuarial rate (as defined in paragraph (1)(B)).

(c) LIMITATION ON DEDUCTIBLES.—

(1) IN GENERAL.—Except as permitted under paragraph (2), a health benefit plan may not provide,

for benefits provided in any plan year, for a deductible amount—

(A) that exceeds—

(i) with respect to benefits payable for items and services furnished to any employee with no family member enrolled under the plan, for a plan year beginning in—

(I) the first calendar year that begins more than 1 year after the date of the enactment of this Act, $250; or

(II) for a subsequent calendar year, the limitation of deductions specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

(ii) with respect to benefits payable for items and services furnished to any employee with a family member enrolled under the plan, for a plan year beginning in—

(I) the first calendar year that begins more than 1 year after the date of the enactment of this Act, $500; or

(II) for a subsequent calendar year, the limitation of deductions specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

(B) for prenatal care or well-baby care described in section 312(a)(4).

If the limitation of deductions computed under subparagraph (A)(i)(II) or (A)(ii)(II) is not a multiple of $10, it should be rounded to the next highest multiple of $10.

(2) WAGE-RELATED DEDUCTIBLE.—A health benefit plan may provide for any other deductible amount instead of the limitations under—

(A) clause (i) of paragraph (1)(A), so long as the amount does not exceed (on an annualized basis) 1 percent of the total wages paid to the employee in the plan year; or

(B) clause (ii) of paragraph (1)(A), so long as the amount does not exceed (on an annualized basis) 2 percent of the total wages paid to the employee in the plan year.

(d) LIMITATION ON COPAYMENTS AND COINSURANCE.—

(1) IN GENERAL.—Subject to paragraphs (2) through (4), a health benefit plan may not—

(A) require payment of any copayment or coinsurance for an item or service for which coverage is required by this title in an amount that exceeds 20 percent of the cost of the item or service;

(B) require payment of any copayment or coinsurance for prenatal care or well-baby care described in section 312(a)(4); or

(C) require payment of any copayment or coinsurance for items and services required under section 312 furnished in a plan year for an employee after the employee has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in paragraph (5)(B)).

(2) EXCEPTION FOR PREFERRED PROVIDERS.—If a health benefit plan establishes reasonable classifica-

tions of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under paragraph (1) in the case of items and services furnished by nonparticipating providers.

(3) EXCEPTION FOR IMPROPER UTILIZATION.—A health benefit plan may provide for copayment or coinsurance in excess of the amount permitted under paragraph (1) for any item or service that an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

(4) MENTAL HEALTH CARE.—In the case of care provided under section 312(a)(5)(B), a health benefit plan may not require payment of any copayment or coinsurance for an item or service for which coverage is required by this title in an amount that exceeds 50 percent of the cost of the item or service.

(5) LIMIT ON OUT-OF-POCKET EXPENSES.—

(A) OUT-OF-POCKET EXPENSES DEFINED.—In this section, the term "out-of-pocket expenses" means, with respect to an employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in

the plan year on behalf of the employee and family covered under the plan.

(B) OUT-OF-POCKET LIMIT DEFINED.—In this section, except as provided in subparagraph (C), the term "out-of-pocket limit" means for a plan year beginning in—

(i) the first calendar year that begins more than 1 year after the effective date of this title, $3,000; or

(ii) for a subsequent calendar year, the out-of-pocket limit specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the out-of-pocket limit computed under clause (ii) is not a multiple of $10, it should be rounded to the next highest multiple of $10.

(C) ALTERNATIVE OUT-OF-POCKET LIMIT.—A health benefit plan may provide for an out-of-pocket limit other than that defined in subparagraph (B) if, for a plan year with respect to

an employee and the employee's family, the limit does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year.

Subtitle C—Certification of Regional Insurers

SEC. 321. DESIGNATION OF HEALTH INSURANCE REGIONS.

The Secretary shall designate by regulation six, seven, or eight health insurance regions for purposes of this subtitle.

SEC. 322. PERIODIC CERTIFICATION OF REGIONAL INSURERS.

(a) IN GENERAL.—The Secretary shall establish procedures for the periodic certification of regional insurers for each health insurance region. Any insurer or group of insurers may apply to be certified as a regional insurer for a region. Subject to subsections (d) and (g), each insurer or group of insurers applying to be certified that meets the eligibility criteria established by subsection (b) may be certified.

(b) MINIMUM ELIGIBILITY STANDARDS FOR CERTIFICATION.—No applicant may be certified as a regional insurer unless the applicant—

(1) meets minimum standards of financial stability established by the Secretary;

(2) meets minimum standards for quality and type of services established by the Secretary;

(3) meets the requirements of section 323;

(4) agrees to enroll any group in the region applying for enrollment that is eligible to enroll with a regional insurer;

(5) agrees to offer only plans and plan options approved by the Secretary to organizations required to enroll with a regional insurer;

(6) agrees that if it offers an indemnity plan or managed-care plan (as described in paragraphs (1) and (2) of section 323(b, respectively)) within the region, it will also make at least two such indemnity plans or managed-care plans, respectively, available in its capacity as regional insurer; and

(7) agrees to allow its offerings to be listed in material distributed by the Secretary, described in such form as the Secretary may prescribe, and to enroll persons who wish to enroll by mail by accepting a completed form to be contained in such material.

(c) APPLICATIONS.—No insurer or group of insurers may be certified as a regional insurer unless it submits to the Secretary an application for such certification in such form and at such time as the Secretary prescribes. Each such application shall include—

(1) specific descriptions of each of the health benefit plans the applicant proposes to offer under section 323(a) as a regional insurer; and

(2) such information as the Secretary determines to be necessary for the Secretary to consider the items described in subsection (d).

(d) ADDITIONAL CONSIDERATIONS.—In reviewing applications for certification as regional insurers, to the extent necessary to provide for effective competition, the Secretary may consider, with respect to each applicant compared to other applicants—

(1) the price of health benefit plans proposed to be offered by the applicant;

(2) the quality and types of services to be provided under the plans;

(3) the experience of the applicant in providing and managing health benefit plans; and

(4) the financial stability of the applicant.

(e) CERTIFICATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first certify regional insurers for each health insurance region. The Secretary shall publish in the Federal Register a list of the regional insurers certified under this section.

(f) EVALUATION AND DECERTIFICATION.—The Secretary shall periodically evaluate the performance of regional insurers under this subtitle. If the Secretary finds that a regional insurer is not substantially meeting the requirements (including considerations under subsection (d)) of this subtitle,

the Secretary may terminate the certification of the insurer or group of insurers.

(g) PERMITTING RESTRICTIONS ON CERTIFICATION IN CERTAIN CASES.—If the Secretary determines that—

(1) every regional insurer in a region has a retention rate that is 20 percent or greater,

(2) such a large retention rate has existed over a period of time, and

(3) there is a failure of competition among regional insurers in the region,

notwithstanding any previous provision of this section, the Secretary may restrict certification of regional insurers for the region, based on a competitive bidding or other system, to those regional insurers (otherwise qualified to be certified) which offer health benefit plans at the lowest rates or at rates below a specified level. For purposes of the previous sentence, the term "retention rate" means, with respect to an insurer or group of insurers, the difference between the amount of premiums collected with respect to health benefit plans offered by the insurer or group under this title and the amount of benefits paid under such plan, expressed as a percentage of the amount of such premiums collected.

(h) REPORT ON REGIONAL INSURER PROGRAM.—Within 2 years after the effective date of this title, the Secretary shall report to Congress on the effectiveness of the re-

gional insurer program established under this subtitle. The Secretary shall include in such report such recommendations for changes in such program as may be appropriate.

SEC. 323. REQUIREMENTS OF REGIONAL INSURERS.

(a) IN GENERAL.—

(1) MINIMUM REQUIREMENTS.—Subject to section 301(b)(2)(B)(ii), each regional insurer shall offer, to employers located in its health insurance region at least one tailored health benefit plan (as defined in section 303(15)) and at least—

(A) two indemnity plans described in subsection (b)(1)—

(i) one of which provides only the minimum benefits required of a health benefit plan; and

(ii) the other of which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region; or

(B) two managed-care plans described in subsection (b)(2)—

(i) one of which provides only the minimum benefits required of a health benefit plan; and

(ii) the other of which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region.

(2) OPTIONAL, ADDITIONAL BENEFITS.—In the case of plans described in subparagraph (A)(i) or (B)(i) of paragraph (1), a regional insurer may offer optional, additional benefits for an additional premium. Such options shall include variations in copayments, deductibles, and the out-of-pocket limit, and additional services and categories of providers. Such benefits shall be subject to approval by the Secretary and, to the maximum extent feasible, shall be standard across carriers within a region.

(b) PLANS DESCRIBED.—

(1) INDEMNITY PLAN.—An indemnity plan described in this subparagraph is a health benefit plan—

(A) that makes payment with respect to items and services furnished by any provider licensed in the State to provide the items and services if—

(i) the provider is a type of provider covered under the plan;

(ii) the provider is not excluded from receiving payment under the plan on the basis

of fraud, abuse, or incompetence (as determined under the rules and procedures of the plan); and

(iii) the plan does not differentiate in payment to providers under the plan based on a contractual arrangement (or lack thereof) between the plan and the provider; and

(B) under which an individual incurs an obligation or makes payment for covered item or service and the plan reimburses the individual or the provider of such services for the amounts payable for such item or service under the plan.

(2) MANAGED-CARE PLAN.—A managed-care plan described in this subparagraph is a health benefit plan not described in paragraph (1), and includes a health benefit plan under which items or services must generally be furnished either by—

(A) providers having a contractual relationship with the plan; or

(B) providers included on a list specified by the plan that consists of a group of providers in a State that is more restricted than all licensed providers in the State.

(c) COMMUNITY-RATED PREMIUMS.—

(1) IN GENERAL.—Subject to section 324(b)(2), each regional insurer shall fix premiums for the plans required under subsection (a) under a community rating system for all employers. An insurer may not set or adjust such premiums based on the age or gender of employees (or their families), on other factors relating to the projected or actual use of health services under the plan, or, except as provided in paragraph (2), on geographical location within the region.

(2) COMMUNITY-RATING ON A LESS THAN REGIONAL BASIS.—A regional insurer shall fix premiums on a community-rated basis for one or more States in a region if the Secretary determines that the region-wide rates otherwise determined for such States would exceed by a substantial percentage the reference rate for such State or States. For purposes of the previous sentence, the term "reference rate" means, for a State or States, the average health care premiums for benefits under this title in the State or States, adjusted upward by the Secretary's estimate of the savings in premiums that may be attributable to the use of the regional insurer system under this title. Nothing in this paragraph shall permit a community-rate to be based on an area other than on a statewide basis covering one or more States.

SEC. 324. MISCELLANEOUS PROVISIONS.

(a) SUBCONTRACTS.—Each regional insurer may enter into subcontracts with other entities in carrying out this subtitle.

(b) ARRANGEMENTS WITH SMALL BUSINESSES.—

(1) IN GENERAL.—The Secretary shall encourage regional insurers to enter into appropriate arrangements with entities representing groups of small businesses (such as small business service bureaus and chambers of commerce) for the provision of administrative services with respect to small businesses enrolled in plans offered by the insurers.

(2) PREMIUM REDUCTION.—Each such insurer shall reduce the premiums otherwise charged for such plans to such small businesses by an amount that reflects the value of such administrative services.

(c) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance and enrollment forms to employers required under section 301(b)(2) to provide health benefit plans of regional insurers. In carrying out this subsection, the Secretary shall, to the maximum extent feasible, enter into contracts (to the extent and in such amounts as may be provided in advance in appropriation Acts) with small business service bureaus, chambers of commerce, and other entities with experience in providing health insurance services to small businesses.

Subtitle D—Regulations and Enforcement

SEC. 331. REGULATIONS.

(a) PROPOSED RULES.—Within 4 months after the date of enactment of this Act, the Secretary shall publish a notice of proposed rule making to carry out this title.

(b) FINAL RULES.—Within 9 months after the date of enactment of this Act, the Secretary shall promulgate final rules to carry out this title. Such notice and final rules shall be made in accordance with section 553 of title 5, United States Code.

(c) EFFECT OF FAILURE TO PROMULGATE RULES.—The failure of the Secretary to promulgate final rules under this title shall not relieve any person or entity to which the provisions of this title apply of any obligations under this title.

SEC. 332. ENFORCEMENT.

(a) CIVIL MONEY PENALTY AGAINST PRIVATE EMPLOYERS.—

(1) 10 PERCENT OF TOTAL WAGES.—Any non-governmental employer that does not comply with section 302(c) or the requirements of section 2601(a) of the Public Health Service Act or section 201(a) of the Fair Labor Standards Act of 1938 in any calendar year shall be subject to a civil penalty of not more than

10 percent of the total amount of the employer's expenditures for wages for employees in that year.

(2) ASSESSMENT PROCEDURE.—A civil money penalty under this subsection shall be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an employer until the employer has been given notice and an opportunity to present its views on such charge.

(3) AMOUNT OF PENALTY.—In determining the amount of the penalty, or the amount agreed on in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of noncompliance by the Secretary.

(4) JUDICIAL REVIEW.—In any civil action brought to review the assessment of such a penalty or to collect such a penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of the penalty, unless in a prior action such a trial de novo was held on the assessment.

(5) USE OF AMOUNTS COLLECTED.—Civil money penalties collected under this subsection shall be credited to the account maintained to provide health bene-

fits under the program established under the amendments made by title IV.

(b) LIABILITY TO INDIVIDUALS FOR DAMAGES.—Any nongovernmental employer that knowingly does not comply with section 302(c) or the requirements of section 2601(a) of the Public Health Service Act or section 201(a) of the Fair Labor Standards Act of 1938 shall be liable for damages (including health care costs incurred) to the employee or the employee's family resulting from such failure to comply.

(c) STATE INELIGIBILITY FOR PUBLIC HEALTH SERVICE ACT FUNDS.—A provision making States and political subdivisions thereof ineligible for funds under the Public Health Service Act if they fail to enroll employees under health benefit plans is set forth in section 2601(b)(1) of such Act.

Subtitle E—Small Business Subsidy

SEC. 341. SMALL BUSINESS SUBSIDY.

(a) IN GENERAL.—In the case of an employer which—

(1) is a small employer,

(2) demonstrates to the satisfaction of the Secretary of Labor that the employer's compliance cost (as defined in subsection (b)) for the employer's fiscal year (beginning with the first full fiscal year in which this title is effective) exceeded the percent specified in sub-

section (c) of the employer's gross revenues (as defined by the Secretary of Labor) for the year, and

(3) requests payment under this subsection,

the Secretary of Labor shall provide for payment to the employer of 75 percent of the excess described in paragraph (2). Payment under the previous sentence shall be made, to the extent feasible, on a calendar quarter basis during the fiscal year involved based upon the best estimates available (with such subsequent adjustment as may be required) or during the employer's succeeding fiscal year.

(b) COMPLIANCE COST DEFINED.—In this section, the term "compliance cost" means, with respect to an employer for a fiscal year, the actual health insurance costs incurred by the employer in that year multiplied by the ratio of—

(1) the average actuarial value of the minimum health benefit plan required to be provided by the employer under this title in that year, to

(2) the average actuarial value of the health benefit plan actually provided.

(c) PERCENT OF GROSS REVENUES APPLIED.—

(1) IN GENERAL.—Except as provided in this subsection, the percent specified in this subsection is 5 percent.

(2) NATIONAL ADJUSTMENT.—For fiscal years beginning during or after the third year in which this

title is effective, the Secretary of Labor shall adjust the 5 percent specified in paragraph (1) by ratio of (A) the national average proportion of health insurance costs per employee per dollar of gross revenues for the preceding year, to (B) the national average proportion of health insurance costs per employee per dollar of gross revenues in 1988.

(d) ADJUSTMENT FOR CERTAIN INDUSTRIES.—In the case of an employer in an industry for which the Secretary of Labor determines that using the ratio of the health insurance costs per employee per dollar of gross revenues in the industry is not an appropriate measure of the financial burden of providing such insurance, the Secretary of Labor may promulgate an alternative standard to be applied.

TITLE IV—ASSURING PROVISION OF HEALTH BENEFITS TO UNDER-POVERTY, NEAR-POVERTY, AND OTHER INDIVIDUALS

SEC. 401. ASSURING PROVISION OF HEALTH BENEFITS TO UNDER-POVERTY, NEAR-POVERTY, AND OTHER INDIVIDUALS.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by redesignating section 1926 as section 1928 and by inserting after section 1925 the following new section:

"PROVISION OF CERTAIN BENEFITS FOR UNDER-POVERTY, NEAR-POVERTY, AND OTHER INDIVIDUALS

"SEC. 1926. (a) REQUIRED COVERAGE OF CERTAIN POPULATIONS.—Notwithstanding any other provision of this title, each State plan approved under this title—

"(1) on and after January 1, 1991, must offer to under-poverty individuals (as defined in subsection (b)(1)) health care benefits applicable to such individuals under subsection (c);

"(2) on and after January 1, 1991, may offer, and on and after January 1, 1996, must offer, to near-poverty individuals (as defined in subsection (b)(2)) benefits applicable to such individuals under subsection (c); and

"(3) on and after January 1, 1996, may offer, and on and after January 1, 1999, must offer, to all other individuals not covered under a health benefit plan under title III of the Basic Health Benefits for All Americans Act benefits applicable to such individuals under subsection (c).

"(b) UNDER-POVERTY INDIVIDUAL AND NEAR-POVERTY INDIVIDUAL DEFINED.—In this section:

"(1) UNDER-POVERTY INDIVIDUAL DEFINED.—The term 'under-poverty individual' means an individual whose family gross income does not exceed 100 percent of the income official poverty line (as defined

by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(2) NEAR-POVERTY INDIVIDUAL DEFINED.—The term 'near-poverty individual' means an individual whose family gross income exceeds 100 percent, but does not exceed 185 percent, of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(3) NO RESOURCE OR ASSET TEST.—A State may not apply any resource standard or methodology as a condition of eligibility for any individual for benefits under this section.

"(4) DETERMINATIONS OF INCOME.—An individual's income, for purposes of this section, shall be determined (at the applicant's option) either—

"(A) by multiplying by four the individual's income (or, if applicable, the family's income) for the three months preceding the month in which the application for such benefits is made; or

"(B) by using the individual's or family's income for the twelve months preceding the month in which the application for such benefits is made.

"(c) BENEFITS.—

"(1) IN GENERAL.—

"(A) GENERAL BENEFITS.—Except as provided in this subsection, benefits under this section with respect to all individuals shall be the same as required of health benefit plans under title III of the Basic Health Benefits for All Americans Act.

"(B) TREATMENT OF ADDITIONAL BENEFITS.—Benefits under this section with respect to all individuals—

"(i) shall include items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnosis, and treatment for children under the age of 21), but

"(ii) may not include coverage under this section for any items or services not described in subparagraph (A) or clause (i).

"(2) COST-SHARING.—

"(A) UNDER-POVERTY INDIVIDUALS.—With respect to under-poverty individuals, the State

plan may not impose any premiums, deductibles, copayments, or cost-sharing.

"(B) NEAR-POVERTY INDIVIDUALS.—With respect to near-poverty individuals, the State plan may impose—

"(i) premiums, but only if the amount of such premiums does not exceed 3 percent of the individual's gross income;

"(ii) deductibles, but only if the amount of such deductibles does not exceed ½ of the maximum deductible amount permitted under section 314(c) of the Basic Health Benefits for All Americans Act; and

"(iii) coinsurance or copayments, but only if—

"(I) the percent of any copayment or coinsurance does not exceed ½ of the percent of copayment or coinsurance permitted under section 314(d)(1) of such Act, and

"(II) there is a limit on out-of-pocket expenses that does not exceed ⅓ of the out-of-pocket limit established under section 314(d)(5)(B) of such Act.

In applying clause (iii)(II), instead of applying an alternative out-of-pocket limit described in section 314(d)(5)(C) of such Act, a State, at its option, may provide for an out-of-pocket limit which does not exceed, on an annualized basis, 3⅓ percent of the gross income of the individual involved.

"(C) COST-SHARING FOR OTHER COVERED INDIVIDUALS.—With respect to other individuals described in subsection (a), the State plan may impose premiums, deductibles, copayments, and coinsurance, but only if—

"(i) such premiums do not exceed the actuarial value of the benefits provided under the plan with respect to such individuals, and

"(ii) the deductibles, copayments, and coinsurance, do not exceed the deductibles, percent of copayments and coinsurance, and out-of-pocket limit on deductibles and coinsurance permitted under section 314 of the Basic Health Benefits for All Americans Act.

"(3) TREATMENT OF INDIVIDUALS COVERED UNDER AN EMPLOYER HEALTH BENEFIT PLAN.—

"(A) IN GENERAL.—Except as provided in this paragraph, in the case of an individual who is

enrolled in a health benefit plan under title III of the Basic Health Benefits for All Americans Act, the individual is not entitled to enroll in the program established under this section.

"(B) BUY-IN FOR UNDER-POVERTY INDIVIDUALS.—In the case of an individual described in subparagraph (A) who is an under-poverty individual, the State plan shall provide for payment of—

"(i) any premiums charged the individual for the applicable category of coverage under the employer's health benefit plan in which the individual is enrolled, except that the State is not required to pay for such amount of a premium as exceeds the lowest premium charged the individual for the applicable category of coverage under any health benefit plan offered the individual under title III of the Basic Health Benefits for All Americans Act; and

"(ii) deductibles and other cost-sharing imposed on the individual under the employer's health benefit plan, but only with respect to the minimum benefits required under such a plan under title III of the Basic Health Benefits for All Americans Act.

"(C) PARTIAL BUY-IN FOR NEAR-POVERTY INDIVIDUALS.—

"(i) IN GENERAL.—In the case of an individual described in subparagraph (A) who is a near-poverty individual, the State plan—

"(I) subject to clause (ii), shall provide for payment of any premiums charged the individual for the applicable category of coverage under the health benefit plan, but

"(II) is not required to provide payment towards any deductibles, copayments, or other coinsurance.

"(ii) LIMITATIONS ON PREMIUMS.—A State is not required to pay for any amount of a premium under clause (i)(I) to the extent such premium exceeds the lower of—

"(I) the lowest premium of any health benefit plan offered the individual for the applicable category of coverage under title III of the Basic Health Benefits for All Americans Act, or

"(II) 20 percent of a monthly actuarial rate that represents the 75th percentile of the community premium rates

charged for basic health benefit plans offered in the State for the applicable category of coverage by regional insurers under section 323(c) of such Act.

"(D) LIMITATIONS ON FEDERAL PAYMENTS.—

"(i) UNDER-POVERTY INDIVIDUALS.—In the case of an individual described in subparagraph (A) who is an under-poverty individual, no payment shall be made under section 1903(a) to a State with respect to payment of any premium under subparagraph (B)(i) to the extent the payment exceeds the lowest amount the State is required to pay under such subparagraph.

"(ii) NEAR-POVERTY INDIVIDUALS.—In the case of an individual described in subparagraph (A) who is a near-poverty individual, no payment shall be made under section 1903(a) to a State with respect to payment of any premium under subparagraph (C)(i)(I) to the extent the payment exceeds the lower of the amounts specified subclauses (I) and (II) of subparagraph (C)(ii).

"(4) BUY-IN FOR INDIVIDUALS.—In the case of an under-poverty individual or a near-poverty individual who is eligible for coverage under, but is not otherwise required to be enrolled in, a health benefit plan, the State may require, as a condition of eligibility for benefits under this section, the individual to enroll under such a plan, but only if the individual's share of premiums and out-of-pocket expenses will be no greater than if the individual had not been required to enroll in a health benefit plan under this paragraph.

"(d) ELIGIBILITY DETERMINATIONS.—

"(1) IN GENERAL.—The State shall provide for determinations of eligibility of an individual applying for benefits under this section not later than the end of the 30-day period beginning on the date the individual files such an application. If a State fails to make such a determination within such period, the individual applicant shall be considered to be so eligible effective on the day after the end of such period and until the State makes a determination to the contrary.

"(2) RECEIPT OF APPLICATIONS.—Each State shall provide for the receipt of applications for benefits under this section at sites (other than welfare offices) throughout the State that provide health care services

to a significant number of individuals entitled to benefits under this section.

"(3) ENROLLMENT AND COVERAGE.—

"(A) FOR UNDER-POVERTY INDIVIDUALS.—In the case of an individual who is determined to be an under-poverty individual, the individual may enroll under this title at any time and coverage of benefits under this section shall apply to services furnished during the 3-month period preceding the month in which the individual was determined to be an under-poverty individual.

"(B) FOR NEAR-POVERTY INDIVIDUALS.—In the case of an individual who is a near-poverty individual, the individual may enroll under this title—

"(i) during the first period of 3 months (beginning after the effective date of this title) in which the individual is a near-poverty individual,

"(ii) during an annual open enrollment period (of not less than one month) established by each State, and

"(iii) during such other periods (including upon loss of coverage under a health benefits plan under title III of the Basic

Health Benefits for All Americans Act) as the Secretary shall require in regulations.

Coverage for such an individual shall take effect as of the first day of the first month in which such enrollment occurs.

"(C) FOR OTHER INDIVIDUALS.—In the case of an individual who is neither an under-poverty individual nor a near-poverty individual, the individual may enroll under this title during the periods described in clauses (ii) and (iii) of subparagraph (B). Coverage for such an individual shall take effect as of the first day of the first month in which such enrollment occurs.

"(4) GUARANTEED MINIMUM ELIGIBILITY PERIOD.—An individual who is determined in a month to be eligible for benefits under this section shall remain eligible for a period of not less than 6 months.

"(e) REIMBURSEMENT.—

"(1) PHYSICIAN SERVICES.—Effective for inpatient or outpatient physician services furnished on or after January 1, 1991, to individuals eligible for benefits under this section, the State plan shall provide for payment based on rates that are not less than the rates recognized for payment purposes for such services under title XVIII.

"(2) OTHER ITEMS AND SERVICES.—Effective for other items and services described in subsection (c)(1) furnished on or after January 1, 1996, to individuals eligible for benefits under this section, the State plan shall provide for payment based on rates that are not less than the rates recognized for payment purposes for such items and services under title XVIII, or, in the absence of applicable payment rates, such rates as the Secretary determines to be comparable to rates that would be appropriate under payment principles used for purposes of such title. In implementing the previous sentence, the Secretary shall, by not later than January 1, 1996, provide for such adjustment to the classification of hospital discharges by diagnosis-related groups and appropriate weighting factors for such groups, otherwise established under section 1886(d)(4), as may be appropriate.

"(f) QUALITY.—

"(1) APPLICATION OF PEER REVIEW ORGANIZATIONS.—The Secretary shall provide for utilization and quality control peer review organizations under part B of title XI to perform review functions for items and services furnished under the title in the same manner as they perform such functions for such items and services furnished under title XVIII.

"(2) DEVELOPMENT OF CLINICAL PRACTICE GUIDELINES.—The State plan shall provide, in determining whether or not items and services provided under this title are medically necessary, for the application of such clinical practice guidelines as the Secretary may develop in consultation with experts in the field.

"(3) MANAGED CARE OPTION.—A State may not provide for benefits under this section through any plan that restricts the provider (among qualified providers) from whom an individual may obtain covered items and services unless—

"(A) the plan has a significant enrollment of individuals not receiving benefits under this title,

"(B) the State makes available to any such individual an option to receive such benefits from any qualified provider,

"(C) the State permits an individual receiving benefits through such a plan, not less often than annually and without cause, to discontinue receiving benefits under that plan, and

"(D) any arrangements for incentive payments for physicians under the plan comply with regulations prescribed by the Secretary to ensure the provision of quality care.

"(g) ADMINISTRATION.—

"(1) IN GENERAL.—Subject to paragraph (2), each State shall provide for administration of this section in the same manner as it provides for administration of the plan established under section 1902(a). In the administration of this section, the State may use a fiscal agent in the same manner as it may use such an agent for the administration of such a plan.

"(2) ELECTION.—A State, with such notice to the Secretary as the Secretary may require, may elect to have this section (insofar as it provides benefits with respect to individuals under subsection (a)) administered with respect to that State by the Secretary (or by such agent as the Secretary may designate). The Secretary may not accept such an election unless the State provides assurances satisfactory to the Secretary that the State will make payments to the Secretary toward the cost of implementing this section in the same amounts and at the same time as the State would make payments under this title but for the fact of such an election.

"(h) APPLICATION OF OTHER PROVISIONS OF THIS TITLE.—

"(1) IN GENERAL.—Except as provided in this subsection, the provisions of this title apply in the implementation of this section.

"(2) PROVISIONS NOT APPLICABLE.—

"(A) NO GENERAL COMPARABILITY.—Section 1902(a)(10)(B)(ii) shall be applied without regard to health care benefits provided, or individuals eligible for such benefits, under this section. The previous sentence shall not affect the application of section 1927(a).

"(B) NO APPLICATION OF PAYMENT RULES.—Section 1902(a)(13)(A) shall apply with respect to payment for health care benefits under this section only with respect to services and periods not covered under subsection (e). The previous sentence shall not be construed as affecting the application of section 1923.

"(C) NO APPLICATION OF OTHER COST-SHARING RULES.—Sections 1902(a)(14) and 1916 (insofar as they relate to specified levels of premiums, deductibles, and cost-sharing) shall not apply with respect to health care benefits provided under this section. In applying the previous sentence, in the case of under-poverty individuals, the provisions of subsection (c)(2)(A) of this sec-

tion shall apply to items and services covered under this section regardless of whether such individuals receive such items and services under this section or as an individual otherwise entitled under the State plan to medical assistance with respect to such services under this title. Nothing in this section shall be construed as permitting a provider of health care benefits under this section to charge, for an item or service for which such benefits are provided under this section, an amount in excess of the amount permitted to be charged with respect to such item or service under the State plan.

"(D) NO GENERAL RETROACTIVE ELIGIBILITY.—Section 1902(a)(34) shall not apply to health care benefits made available under this section. The previous sentence shall not be construed as affecting the application of subsection (d)(3)(A).

"(E) NO APPLICATION OF TRANSITION RULES.—Sections 1902(e)(1) and 1925 shall not apply with respect to—

"(i) under-poverty individuals described in subsection (b)(1) on or after January 1, 1991, or

"(ii) near-poverty individuals described in subsection (b)(2) on or after the earlier of the date on which the State elects, under subsection (a)(2), to offer health care benefits under this section to such individuals or January 1, 1996.

"(F) NO STATE 209(b) SECTION OPTION.—Section 1902(f) shall not permit any State an election with respect to the provision of health care benefits under this section.

"(G) NO APPLICATION OF INCOME LIMITS.—Section 1903(f) shall not apply with respect to amounts expended for health care benefits in accordance with this section.

"(H) NO APPLICATION OF LIEN PROVISION.—Section 1917 shall not apply with respect to individuals eligible for benefits under this title only because of this section.

"(3) MISCELLANEOUS.—

"(A) In applying section 1902(a)(8) to applications for benefits under this section, coverage of benefits shall be provided with reasonable promptness within 30 days of the date of an eligibility determination.

"(B) Sections 1902(a)(17)(D) and 1902(r) shall not apply to determinations of eligibility for benefits under this section.

"(C) Section 1902(a)(30)(A) and (B) shall not apply to benefits and payments made under this section.

"(D) Sections 1902(a)(30)(C), 1902(e)(2), and 1903(m) shall apply to enrollment in, and to services furnished by, health maintenance organizations under health benefit plans under this section (including managed care options under subsection (f)(3)) in the same manner as they apply to such organizations providing services under the remainder of this title.

"(E) Section 1903(a) shall apply to payment for amounts expended as medical assistance and for other State expenditures under this section in the same manner as such section applies to payment for amounts as medical assistance and other State plan expenditures under other provisions of this title. For purposes of this title, the term 'medical assistance', defined in section 1905(a), also includes payment of part or all of the cost of health care benefits under this section.

"(F) Section 1905(e) shall apply to health care benefits under this section in the same manner as it applies to services otherwise provided under this title.

"(G) Section 1913 shall not apply to payment for health care benefits under this section.

"(H) A State's election under section 1915(d) shall not apply to an individual who is only eligible for benefits under this title because of this section.

"(j) MISCELLANEOUS.—

"(1) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirements if the State had in effect a plan approved under this title.

"(B) NO APPLICATION IN COMMONWEALTH AND TERRITORIES.—This section shall only apply

to a State that is one of the 50 States or the District of Columbia.

"(2) FAILURE TO PRESCRIBE REGULATIONS.—The failure of the Secretary to prescribe any regulations under this section shall not relieve a State of any responsibility for complying with this section.

"(3) OPTIONAL TREATMENT OF CERTAIN PROFESSIONAL SERVICES.—In applying subsection (c)(1), the term 'physician services' may, at the option of the State, include professional services provided by a licensed practitioner acting within the scope of State law if such services would be treated as physician services if furnished by a physician.".

(b) CONFORMING AMENDMENTS.—Section 1902(a)(52) of such Act (42 U.S.C. 1396a(a)(52)) is amended—

(1) by striking "and" at the end of paragraph (51),

(2) by striking the period at the end of paragraph (52) and inserting "; and", and

(3) by inserting after paragraph (52) the following new paragraph:

"(53) meet the requirements of section 1926 (relating to provision of health benefits to under-poverty, near-poverty, and other individuals).".

SEC. 402. MEDICAID PROGRAM MODIFICATIONS.

Title XIX of the Social Security Act is amended by inserting after section 1926 the following new section:

"PROGRAM MODIFICATIONS

"SEC. 1927. (a) REMOVAL OF AMOUNT, DURATION, AND SCOPE LIMITATIONS ON CERTAIN ITEMS AND SERVICES.—Notwithstanding any other provision of this title, with respect to benefits described in section 1926(c)(1)(A), effective on and after January 1, 1991, the State plan under this title may not impose any limitations on amount, duration, or scope (other than those that may be applicable with respect to particular services under section 312 of the Basic Health Benefits for All Americans Act) for individuals eligible for benefits under this title who are not described in section 1926(a).

"(b) REIMBURSEMENT.—

"(1) PHYSICIAN SERVICES.—Effective for inpatient or outpatient physician services furnished on or after January 1, 1991, to individuals eligible for benefits under this title, each State plan under this title shall provide for payment based on rates that are not less than the rates recognized for payment purposes for such services under title XVIII.

"(2) OTHER ITEMS AND SERVICES.—Effective for other items and services described in section 1926(c)(1) furnished on or after January 1, 1996, to individuals

eligible for benefits under this title, the State plan shall provide for payment based on rates that are not less than the rates recognized for payment purposes for such items and services under title XVIII, or, in the absence of applicable payment rates, such rates as the Secretary determines to be comparable to rates that would be appropriate under payment principles used for purposes of such title. In implementing the previous sentence, the Secretary shall, by not later than January 1, 1996, provide for such adjustment to the classification of hospital discharges by diagnosis-related groups and appropriate weighting factors for such groups, otherwise established under section 1886(d)(4), as may be appropriate.

"(c) OPTIONAL PROVISION OF PRESCRIBED DRUGS.—Notwithstanding any other provision of this title, a State plan under this title may, at the State's option, make medical assistance available with respect to prescribed drugs for any reasonable classification of individuals (other than individuals described in section 1902(a)(10)(A)), but only if—

"(1) the individuals are eligible to receive benefits under section 1926, and

"(2) the amount, scope, and duration of such assistance does not exceed the amount, scope, and duration of medical assistance made available with respect

to prescribed drugs for individuals described in section 1902(a)(10)(A).".

SEC. 403. EFFECTIVE DATE.

The amendments made by this title shall take effect on January 1, 1991, without regard to whether regulations to implement such amendments are promulgated by such date.

TITLE V—EFFECTIVE DATE FOR TITLES I THROUGH III

SEC. 501. EFFECTIVE DATE.

(a) GENERAL RULE.—Except as otherwise provided in this section, title III of this Act (and the amendments made by titles I and II) shall take effect on January 1 of the second year that begins after the date of the enactment of this Act.

(b) EXISTING PLANS.—In the case of an employer that, on the date of the enactment of this Act, has in effect a health benefit plan, title III (and the amendments made by titles I and II) shall not apply until the first day of the second plan year that begins after the date of the enactment of this Act.

(c) STATE AND LOCAL GOVERNMENTS.—In the case of an employer whose revenue is raised by a taxing authority, a health benefit plan maintained by the employer shall not be required to meet the requirements of section 314(b)(1)(A)(ii) until the first day of the third plan year that begins after the date of the enactment of this Act. During the period begin-

ning on the effective date prescribed under subsections (a) and (b) and ending on the first day of the third plan year that begins after the date of the enactment of this Act, employee participation in such plan shall be voluntary unless otherwise required by the plan.

(d) ADVISORY BOARD.—Section 311(b)(4) shall take effect on the date of enactment of this Act.

(e) SMALLER BUSINESS TRANSITION.—

(1) IN GENERAL.—Subject to paragraph (2), in the case of an employer that did not employ any employees, or that normally employed fewer than 6 employees, on a typical business day during the calendar year immediately before the effective date described in subsection (a), title III (and the amendments made by titles I and II of this Act) shall not apply until January 1 of the fourth year that begins after the date of the enactment of this Act, or, if earlier, January 1 of any year following the first year in which the employer normally employed 6 or more employees on a typical business day during the year.

(2) TAILORED HEALTH BENEFIT PLAN ONLY.—During the period beginning on the effective date prescribed in paragraph (1) and ending on December 31 of the sixth year that begins after the date of the enactment of this Act, in the case of an employer that em-

ploys an average of 5 or fewer employees, the health benefit plan of the business shall only be required to provide a tailored health benefit plan (as defined in section 303(15)).

SEC. 502. POLICY RESPECTING ADDITIONAL BENEFITS.

(a) IN GENERAL.—After the date of the enactment of this Act, no employer shall be required under title III to provide any health benefit in addition to the benefits required to be provided under section 312(a) (as in effect on the date of the enactment of this Act) unless—

(1) such additional health benefit is for a service that State medicaid plans (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) are required to cover for individuals receiving cash assistance under part A of title IV of such Act (42 U.S.C. 601 et seq.); and

(2) before the enactment of such requirement, the benefits and costs of requiring the provision of such additional health benefit have been analyzed and considered by Congress.

(b) REPORTS.—

(1) IN GENERAL.—In carrying out subsection (a)(2) with respect to the consideration of a proposed additional health benefit, Congress shall request a report from the Institute of Medicine of the National

Academy of Sciences or a public or nonprofit entity with expertise relating to health benefits. Any such report shall—

(A) analyze and summarize such proposed additional health benefit; and

(B) contain an estimate of the economic and health impacts of such proposed additional health benefit.

(2) CONSULTATION.—Any such report shall be prepared in consultation with interested members of the public and with individuals and entities having expertise with respect to such proposed additional health benefit.

○